## APPENDIX 5A

## PRIOR AUTHORIZATION REQUEST FORM (PA/RF) PSYCHOTHERAPY

7 SILLING PROVIDER NAME, ADDRESS, ZIP CODE:  I. M. Provider 1 W. Williams Anytown, WI 55555  Anytown, WI 555	MAIL TO: E.D.S. FEDERAL CORF PRIOR AUTHORIZATION 6406 BRIDGE ROAD SUITE 88 MADISON, WI 53784-00 2 RECIPIENT'S MEDICAL ASS 1234567890 3 RECIPIENT'S NAME (LAST. RECIPIENT. IM 5 DATE OF BIRTH	DN UNIT	D NUMBER	6 SEX	PA/RF CN # A.T. # P.A. # 1		4 RECIPIEN 609 Any		EET. CITY, ST	,
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